OUT-OF-POCKET HEALTH CARE EXPENSES FOR MEDICARE HMO BENEFICIARIES: ESTIMATES BY HEALTH STATUS, 1999–2001

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Marsha Gold, Sc.D., has been a Senior Fellow at Mathematica Policy Research since 1992. Dr. Gold's current work focuses on arrangements between HMOs and providers, Medicare managed care, and Medicaid managed care. Her interest in state health policy, managed care, and policy-sensitive analysis derives from over 25 years of experience in both the public and private sector. Previously, she was director of research and analysis for the Group Health Association of America and, earlier, director of policy and program evaluation for the Maryland Department of Health and Mental Hygiene. Dr. Gold, who earned her doctorate from the Harvard School of Public Health, has published extensively on such topics as managed care, health care access, and ambulatory care.

EXECUTIVE SUMMARY

The availability of pharmaceutical benefits and coverage for Medicare's cost-sharing requirements at relatively low premiums has attracted Medicare beneficiaries to managed care plans (Gold et al. 2001). After an expansion in the mid-1990s, however, managed care benefits are shrinking. Medicare has reduced its annual increases in payments to health plans and provider concerns and other factors have created market challenges (Gold 2001). This paper explores the effect these changes in benefits have had on enrollees by examining trends in estimated out-of pocket expenses, particularly as these vary with beneficiaries' health status.

The analysis is based on a database we created from publicly available data from Medicare Compare, a consumer-oriented summary of information on Medicare+Choice plans, and the Centers for Medicare and Medicaid Services' (CMS) State/County/Plan file. The data reflect benefits, beneficiary cost-sharing requirements, and enrollment levels by county. We also licensed HealthMetrix Research, Inc.'s methodology, which includes cost and utilization estimates, to approximate enrollee cost-sharing across Medicare+Choice plans. Out-of-pocket estimates reflect four components of cost: (1) Part B premiums; (2) supplemental Medicare+Choice premiums; (3) out-of-pocket spending for prescription drugs; and (4) out-of-pocket spending for other acute care services, such as physician services, inpatient hospital visits, emergency room visits, and preventive care. These estimates understate total out-of-pocket costs because they exclude cost-sharing for some other services (e.g., mental health and rehabilitative care) and benefits that standard medical insurance products typically do not cover (e.g., long-term care).

Our analysis found that out-of-pocket spending for Medicare+Choice enrollees can be substantial and varies significantly with health status. In 2001, the average enrollee in good health spent $1,195 annually out-of-pocket on health care, while an enrollee in poor health spent $3,578, or about three times as much. Growth in out-of-pocket spending also appears to be increasing most rapidly for enrollees in poor health. Enrollees in good health saw costs increase $358 (43%) from 1999 to 2001. In comparison, out-of-pocket costs increased $639 (53%) for enrollees in fair health and $1,367 (62%) for enrollees in poor health. Despite substantial out-of-pocket costs for low- and moderate-income enrollees in Medicare+Choice plans, these expenses remain less than those for beneficiaries with a supplemental Medigap policy.

The purpose of health insurance is to pool the risks of health care expenses for those with varying needs. Policymakers should be particularly concerned with our

findings, which show large out-of-pocket spending for beneficiaries in fair or poor health despite being covered by a Medicare managed care plan. Limitations in Medicare's benefit package (the exclusion of drug coverage and the absence of a catastrophic limit on total out-of-pocket spending) mean that beneficiaries incur substantial risk of out-of-pocket spending. This risk is exacerbated by the relatively low incomes of Medicare beneficiaries with below-average health status (Gold et al. 2001). Given Medicare+Choice's changing market, the risk for enrollees in poor health will become even worse as health plans increase premiums and reduce benefit levels. Policymakers should consider whether an improvement in Medicare benefits is needed to ensure Medicare's ability to meet its social insurance objective.

OUT-OF-POCKET HEALTH CARE EXPENSES FOR MEDICARE HMO BENEFICIARIES: ESTIMATES BY HEALTH STATUS, 1999–2001

INTRODUCTION

For the past three years, The Commonwealth Fund has commissioned Mathematica Policy Research, Inc. (MPR) to monitor the benefits and premiums of managed care plans that participate in Medicare+Choice. Earlier work has documented trends in benefits, which remained stable from 1998 to 1999 (Gold et al. 1999) but declined in 2000 (Cassidy and Gold 2000) and again in 2001 (Achman and Gold 2002). Over the past decade, we have seen an increase in the offering of zero-premium products that provide some prescription drug coverage, followed by a reduction in benefits that began in 2000 (Figure 1).

In this report, we develop estimates of how changes in premiums and benefits in Medicare+Choice plans from 1999 to 2001 likely affected out-of-pocket costs for enrollees. Estimates include four components of enrollee cost-sharing: (1) Part B premiums (which enrollees are required to pay); (2) Medicare+Choice plan premiums; (3) prescription drug spending; and (4) other cost-sharing (including inpatient hospital or urgent care visit copays, primary care and specialist physician visit copays, and hearing and eye exams). This allows us to see not merely the general trends, but also the specific categories of enrollee cost-sharing that are increasing. Because an enrollee's out-of-pocket costs depend on both plan benefits and enrollee utilization patterns, estimates are provided for enrollees in good, fair, and poor health.

METHODOLOGY

Our analysis is based on a merged file we created from data in the Centers for Medicare and Medicaid Services' (CMS) Medicare Compare database and in its State/County/Plan Quarterly Market Penetration File. Both are publicly available on the CMS and Medicare websites. The merged file includes information on Medicare+Choice contracts, service areas, county enrollments, and benefits. In addition, we licensed HealthMetrix Research, Inc.'s HMO CostShare Report methodology to generate the out-of-pocket spending estimates that are new to this report.

The Medicare Compare database provides detailed benefit information at the plan level, "plan" being defined as a unit within a contract that offers the same benefit and cost-sharing structure to all members within a specified service area.[1] Enrollment data are

[1] We used the February 2001 release of Medicare Compare for 2001, which included changes health plans made following the Beneficiary Improvement and Protection Act of 2000 (BIPA).

based on CMS's State/County/Plan Quarterly Market Penetration File, which tracks enrollment in each county by contract.[2]

CMS allows managed care organizations (MCOs) to offer more than one plan, or benefit package, within a contract service area. MCOs may also offer differing plans across portions of the contract service area, called segments, but must offer the same benefits with the same costs to all enrollees within a plan. We used contract segments as the basic unit of analysis because plan options are the same for all beneficiaries within a segment.

MCOs may offer more than one plan to enrollees in a contract segment; unfortunately, enrollment information is available only at the contract level. We have no way of knowing how many enrollees chose each option when more than one was available (about 40% of contract segments offered more than one option in 2001). We included only basic plans in our analysis because they provide a picture of the most basic level of coverage available to Medicare+Choice enrollees. We defined the basic plan as the plan with the lowest premium within a contract segment. When the premiums for more than one plan within a contract segment were the same, we chose the plan with prescription drug coverage.[3]

HealthMetrix uses its HMO CostShare Report methodology to compare the estimated annual out-of-pocket costs associated with specific Medicare+Choice plans in markets across the country. The methodology creates the estimates by making assumptions about cost and utilization for three types of health care expenditures for Medicare managed care enrollees: premiums, out-of-pocket spending for prescription drugs, and other out-of-pocket spending (largely acute care costs for physician visits, medical care, and some preventive services). In addition to these costs, MPR included Medicare's Part B premium. The model assumes no change in utilization patterns from 1999 to 2001. The only prices assumed to have changed during the time period were those for prescription drugs. The Appendix shows the assumptions used in the model and their sources.

To apply the model to our database of health plan information, we worked with HealthMetrix to develop an algorithm that translated the methodology to be compatible with the information we had on the basic plans represented in our database. Although the out-of-pocket costs for Medicare Part B and Medicare+Choice premiums do not vary by individual within a Medicare+Choice plan, the costs associated with prescription drugs

[2] We used the March 2001 State/County/Plan file for 2001 enrollment information.

[3] Because traditional Medicare does not cover prescription drugs, Medicare+Choice HMO enrollees often cite the availability of prescription drug coverage as a reason for enrolling in a plan.

and other medical services do vary based on level of utilization. Therefore, our estimates aim to illustrate the typical costs for enrollees in good, fair, and poor health, respectively. We also provide an estimate for "all enrollees." This estimate was created by weighting out-of-pocket cost estimates for those in good, fair, and poor health according to the reported health status of Medicare beneficiaries enrolled in risk HMOs in the 1998 Medicare Current Beneficiary Survey (MCBS).[4] Each contract segment then was weighted by enrollment to produce the averages shown.

Readers should note that these estimates are limited to acute care and preventive expenses only. They do not cover such costs as hearing aids (which some plans do cover but at varying levels of cost to enrollees), mental health care, or podiatrist visits. The estimates also do not include health care costs that are not generally covered by Medicare or private health insurance, such as long-term care.

ENROLLEE OUT-OF-POCKET SPENDING BY HEALTH STATUS

Even with Medicare+Choice coverage, Medicare beneficiaries still incur substantial out-of-pocket health care costs (Figure 2). The amounts of these costs vary considerably by health status, but we estimate that even an enrollee in good health spends an average of $1,195 per year. Expenses are even higher for those in fair or poor health —$1,842 and $3,578, respectively.

The nature of insurance is to pool risks across individuals of different health status. This dynamic is reflected in the components of Medicare+Choice enrollee out-of-pocket spending. Regardless of health status, each enrollee paid $600 annually for Medicare Part B and an average of $275 annually for the additional Medicare+Choice coverage. Together, the estimated premiums represent 73 percent of total estimated out-of-pocket costs for those in good health, 47 percent of costs for those in fair health, and only 25 percent of costs for those in poor health. The reason for this is that use increases as health status worsens, creating additional out-of-pocket expenses for the enrollee.

Because of the way Medicare and Medicare+Choice benefits are structured, out-of-pocket spending differences by health status are particularly apparent when one examines prescription drug spending (Table 1). Enrollees in poor health spend an

[4] The MCBS uses self-reported health status ratings of excellent, very good, good, fair, and poor. We corresponded our weights so that the good-health-status out-of-pocket estimates were weighted according to the percentage reporting excellent, very good, or good health status (78.62%). Fair-health estimates were weighted according to the percentage reporting fair health (15.33%), and poor-health estimates were weighted according to the percentage reporting poor health (6.05%) (MCBS 1998).

estimated 13.2 times more on pharmaceuticals than enrollees in good health. Substantial differences in spending according to health status also exist with respect to other cost-sharing requirements, for services such as physician visits and hospital stays. Our estimates show enrollees in poor health spend 3.8 times more in out-of-pocket costs for services other than pharmaceuticals than those in good health.

Table 1. Average Annual Enrollee Out-of-Pocket Costs in Medicare+Choice Plans, 1999–2001 (weighted by enrollment)

	1999	2000	2001	Absolute Change 1999–2001	Percent Change 1999–2001
Annual Part B Premium	$546.00	$546.00	$600.00	$54.00	9.9%
Annual M+C Premium	$63.37	$173.16	$275.24	$211.87	334.3%
Rx Cost-Sharing					
All	$234.19	$291.75	$344.02	$109.83	46.9%
Good Health	$109.74	$135.09	$157.71	$47.97	43.7%
Fair Health	$434.61	$539.69	$610.88	$176.27	40.6%
Poor Health	$1,343.62	$1,699.25	$2,088.98	$745.36	55.5%
Other Cost-Sharing					
All	$132.08	$174.42	$218.74	$86.66	65.6%
Good Health	$117.08	$142.99	$161.57	$44.49	38.0%
Fair Health	$159.41	$244.49	$356.02	$196.61	123.3%
Poor Health	$257.81	$405.23	$613.84	$356.03	138.1%
Total Annual Out-of-Pocket Costs					
All	$975.64	$1,185.33	$1,438.00	$462.36	47.4%
Good Health	$836.19	$997.24	$1,194.52	$358.33	42.9%
Fair Health	$1,203.39	$1,503.34	$1,842.14	$638.75	53.1%
Poor Health	$2,210.80	$2,823.64	$3,578.06	$1,367.26	61.8%
Total Cost Ratio for Poor to Good Health	2.64	2.83	3.00		

Note: The "all" estimate was created by weighting the good, fair and poor health status estimates according to the reported health status of Medicare beneficiaries enrolled in risk HMOs in the 1998 Medicare Current Beneficiary Survey (MCBS).

Source: MPR Analysis of Medicare Compare data using HealthMetrix Research Inc.'s Medicare HMO CostShare Reports.

The large variations in out-of-pocket prescription drug spending caused by health status are understandable when one considers that traditional Medicare does not cover these expenses and that pharmaceutical costs have been rising rapidly in recent years. Many Medicare+Choice plans provide some coverage, but typically, it is limited. Though 70 percent of Medicare+Choice enrollees had some drug coverage in 2001, 50 percent had a prescription drug benefit limited to $1,000 or less (Achman and Gold 2001). A $1,000 annual limit amounts to about $83 per month, which would, at most, cover two to three prescriptions a month for most enrollees. Those in poor health—relying on five or six medications per month—can use up their prescription coverage quickly under such a plan. Any additional costs for the year must be borne entirely out-of-pocket and over and above the copays the enrollee already paid for covered prescriptions. In contrast, an

enrollee in good health with minimal prescription needs likely can cover them under the annual limit and confine out-of-pocket expenses to required copays. As prescription drug limits are reduced, the spending disparity between enrollees in good and poor health is likely to increase.

Despite the rather significant costs associated with Medicare+Choice plans, they appear to remain a good value compared with Medigap supplemental insurance. It is difficult to assess the out-of-pocket costs for those enrolled in Medigap because premiums can vary by health status, age, location, and plan chosen; however, the General Accounting Office (GAO) estimated that the average annual premium for a standardized Medigap policy in 2000 was $1,300 (GAO 2001). Beneficiaries with Medigap also pay the Part B premium—$546 in 2000. These costs total $1,846 and do not include prescription drug costs (only 8% of standardized Medigap policyholders are enrolled in the two plans with prescription drug coverage) or any other cost-sharing these plans require. Maxwell, Moon, and Segal (2001) estimated out-of-pocket costs in 2000 for elderly Medicare beneficiaries, excluding those in Medicare managed care, and found the average for a noninstitutionalized Medicare beneficiary was $3,142. This figure is considerably higher than our estimates for Medicare+Choice beneficiaries in good and fair health in 2001 and just about $400 less than our 2001 estimate for those in poor health.

ENROLLEE OUT-OF-POCKET SPENDING OVER TIME

From 1999 to 2001, out-of-pocket spending for Medicare+Choice enrollees increased substantially within every component of spending (Figure 3). Growth was most moderate, only $54 per year, for the congressionally set Part B premium. In percentage terms, out-of-pocket cost increases were the greatest for Medicare+Choice premiums (334%), reflecting the increasing number of plans that charge a premium and the higher level of those premiums. The percentage increase, however, is largely an artifact of the low base in 1999. The actual average dollar increase in Medicare+Choice premiums from 1999 to 2001 was $212 per year.

The growth in out-of-pocket costs from 1999 to 2001 was most substantial for those in the poorest health, reflecting the decreasing number of plans that include prescription drug coverage and the increasing number of plans that charge coinsurance for hospital inpatient stays. Because we held utilization constant over the three years, the increase in out-of-pocket costs can only be attributed to changes in benefit packages and increases in prescription drug prices. Enrollees in good health saw out-of-pocket costs increase $358 (43%). In comparison, out-of-pocket costs increased $639 (53%) for enrollees in fair health and $1,367 (62%) for enrollees in poor health. The increase in

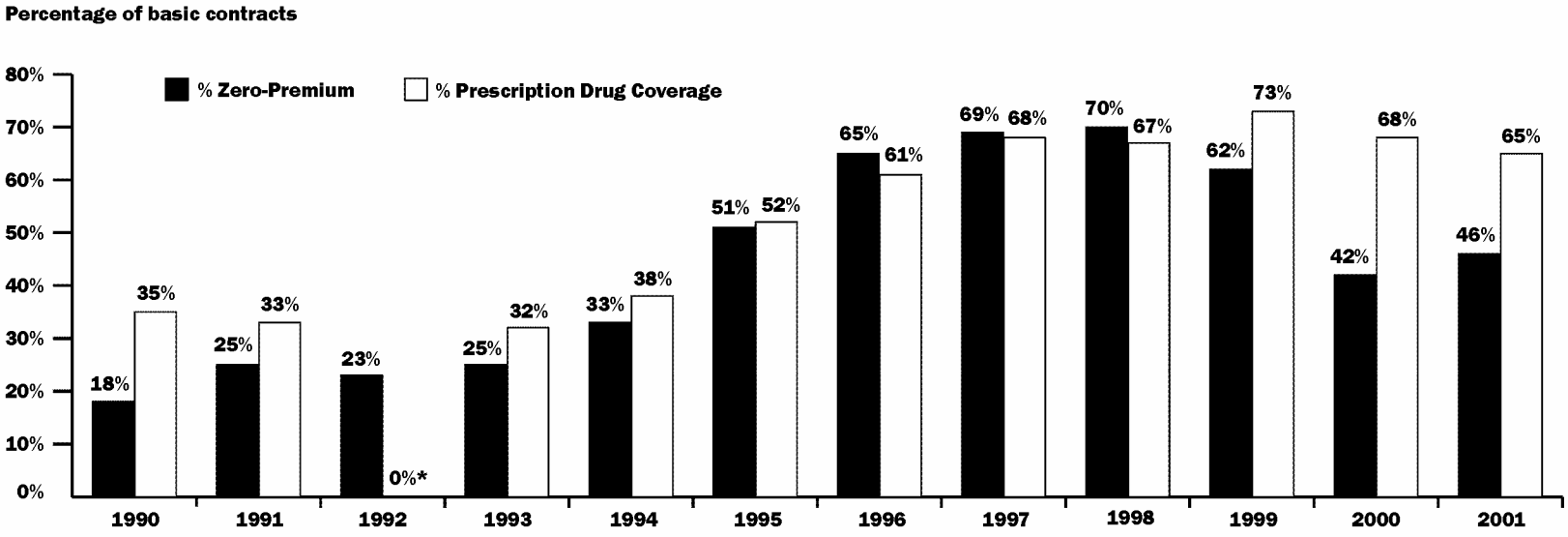
prescription drug costs alone ($745) accounted for nearly 55 percent of the total increase in costs for enrollees in poor health. Because cost increases were greatest for enrollees in poor health, the disparity in total out-of-pocket costs between enrollees in good and poor health increased from 1999 to 2001. In 1999, Medicare+Choice enrollees in poor health spent an average 2.6 times more out-of-pocket than enrollees in good health; by 2001 they were spending three times as much.

CONCLUSION

The purpose of health insurance is to pool the risks of health care expenses for individuals with varying health care needs; however, Medicare benefits leave beneficiaries with substantial out-of-pocket costs. Although enrolling in a Medicare+Choice plan does reduce these costs somewhat, enrollees still face significant health care expenses.

Policymakers should be particularly concerned with our findings that show large out-of-pocket spending for beneficiaries in fair or poor health despite the managed care coverage they have obtained. Limitations in Medicare's benefit package (the exclusion of drug coverage and the absence of a catastrophic limit on total out-of-pocket spending) mean that beneficiaries incur substantial risk of out-of-pocket spending. That risk is exacerbated by the relatively low incomes of Medicare beneficiaries with below-average health status (Gold et al. 2001). In Medicare+Choice's changing market, the risk for enrollees in poor health will become even greater as health plans increase premiums and reduce benefit levels. Policymakers should consider whether an improvement in Medicare benefits is needed to ensure Medicare's ability to meet its social insurance objective.

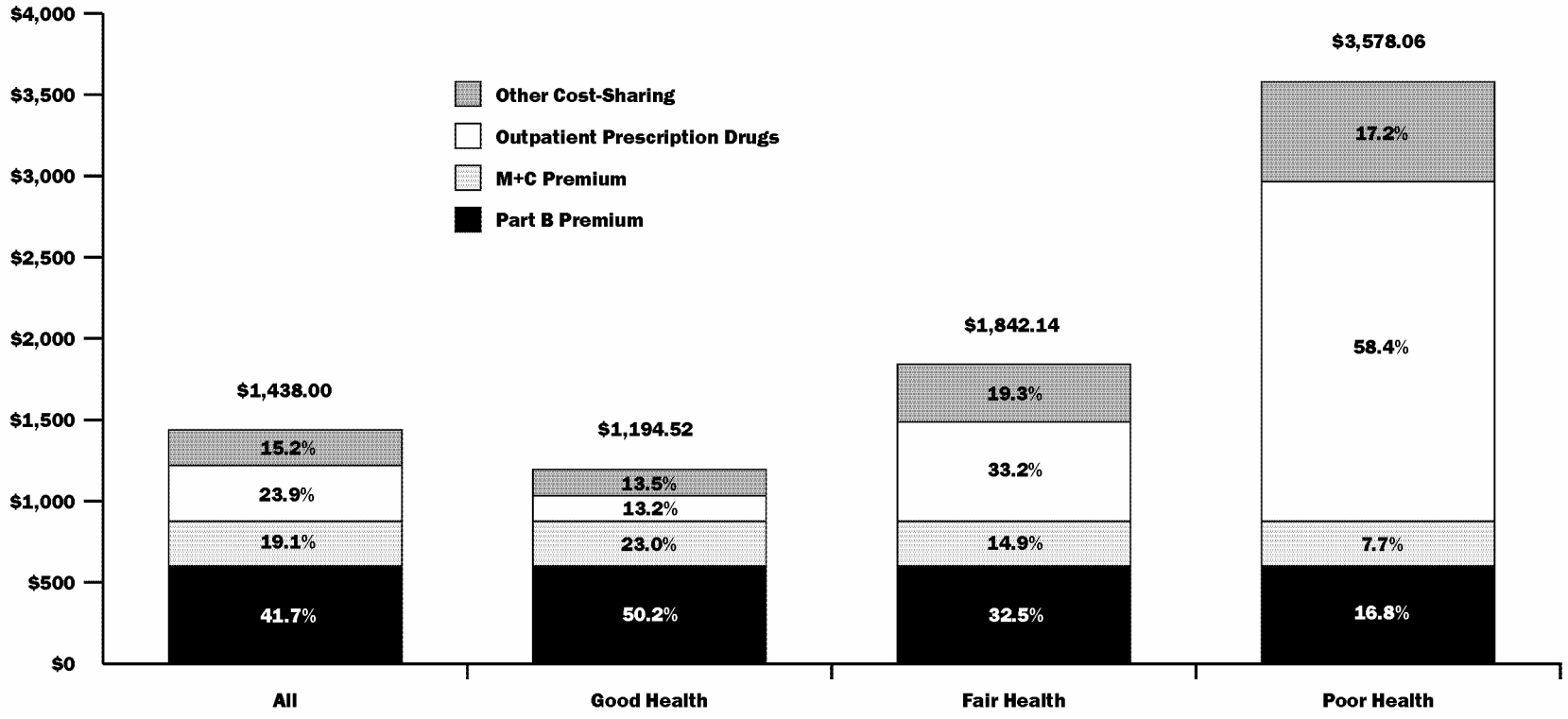
Figure 1. Pharmacy Benefits and Zero-Premium Products in Medicare Risk/M+C Contracts, 1990–2001



* Not presented (data problematic).

Source: MPR compilation of HCFA Monthly Report data (1990–1998) and Medicare Compare (1999–2001), for The Commonwealth Fund. Data for 2001 is post-BIPA.

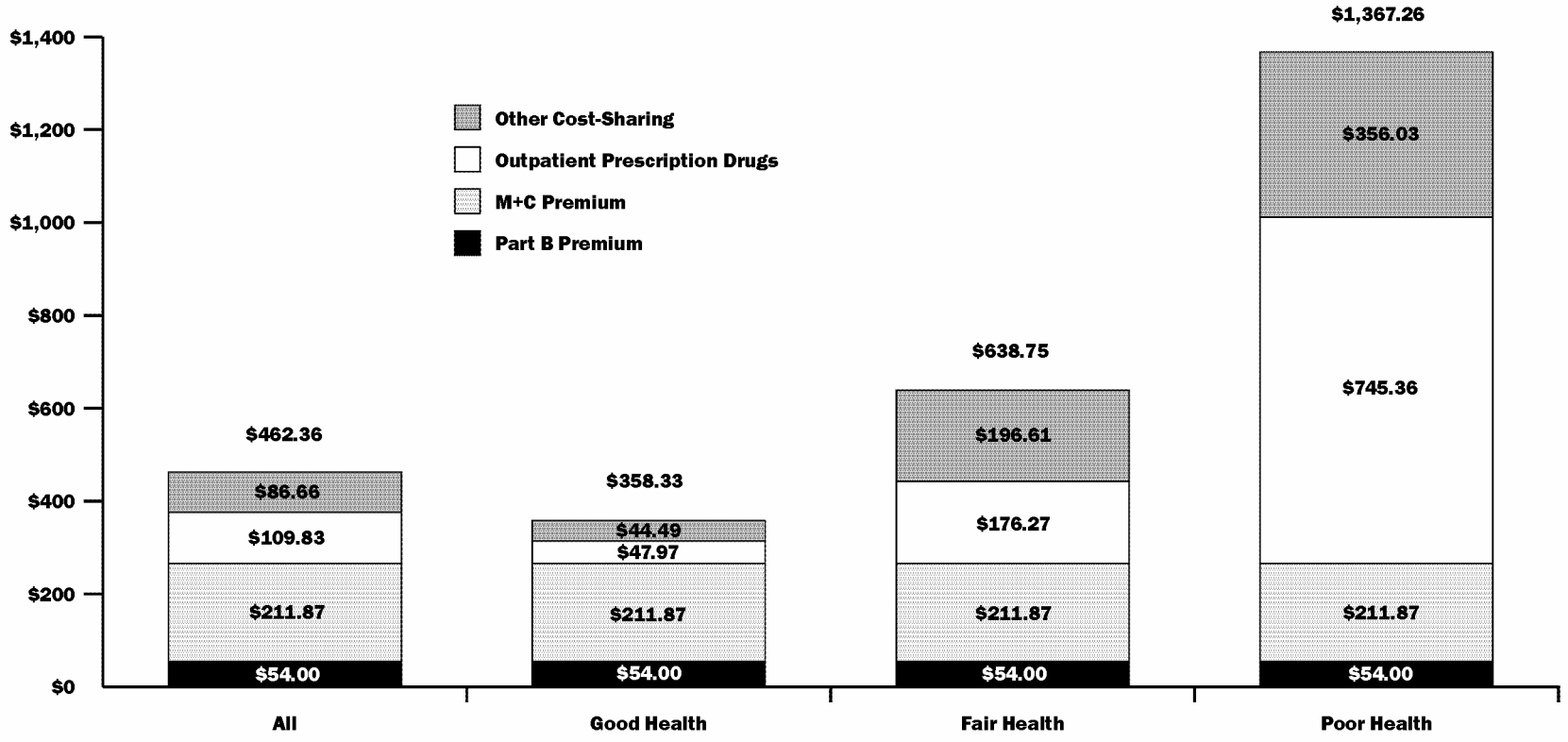
Figure 2. Components of Medicare+Choice Enrollee Out-of-Pocket Costs, 2001



Note: The "all" estimate was created by weighting the good, fair, and poor health status estimates according to the reported health status of Medicare beneficiaries enrolled in risk HMOs in the 1998 Medicare Current Beneficiary Survey (MCBS).

Source: MPR analysis of Medicare Compare using HealthMetrix Research Inc.'s Medicare HMO CostShare Report methodology.

Figure 3. Absolute Dollar Increases in Medicare+Choice Out-of-Pocket Spending, 1999–2001



Note: The "all" estimate was created by weighting the good, fair, and poor health status estimates according to the reported health status of Medicare beneficiaries enrolled in risk HMOs in the 1998 Medicare Current Beneficiary Survey (MCBS).

Source: MPR analysis of Medicare Compare using HealthMetrix Research Inc.'s Medicare HMO CostShare Report methodology.

APPENDIX. 1999–2001 COSTSHARE COMPARISON ASSUMPTIONS

The CostShare comparison methodology for Medicare plans features annual utilization examples for seniors based on health status category (*Good* [H], *Fair* [F], *Poor* [P]). CostShare includes both fixed and variable cost-sharing assumptions for each health status category as indicated below. Unless otherwise indicated, all services are rendered by in-network providers. Utilization assumptions are not intended to represent actual enrollee experiences for any Medicare product or geographic region.

Fixed Assumptions (Identical services and premiums for all health status categories)	
Prevention Services[1] • Physical Exam • Vision Exam • Hearing Exam • Dental Care	 > All prevention services utilized once annually per enrollee. > If included as a plan benefit, the applicable copayment is used. > If no benefit applies, the following out-of-pocket costs are used: Vision ($50) Hearing ($50) Dental ($75)
Plan Premium	> Based on 12-month enrollment.

Variable Assumptions (Services vary depending on health status category [G], [F], [P])	
Office Visits[2]	> [G] category includes 4 Primary Care Physician visits. > [F] category includes 6 Primary Care Physician visits and 6 specialist visits. > [P] category includes 12 Primary Care Physician visits and 12 specialist visits.
Urgent Care Visit[3]	> [G] category includes 1 out-of-area urgent care visit (non-office).
Emergency Visits[4]	> [F] category includes 2 ER visits resulting in 1 hospitalization. > [P] category includes 4 ER visits resulting in 2 hospitalizations. > Applicable *waiver of ER copayment* provisions are included.
Inpatient Admission[5]	> Applicable copayments or annual coinsurance provisions are included with inpatient admissions for [F] and [P] categories only.

[1] Cost assumptions for these services are based on mean cost projections in 1996–1997 ACR filings for about 18 MCOs that were active in the Ohio Medicare risk market at the time. The individual cost assumptions for these services did not change during the 1999–2001 period.

[2] The baseline annual utilization data for these benefits were from actuarial projections in 1996–1997 ACR filings for Ohio MCOs. HealthMetrix Research adapted the actuarial utilization projections as the utilization profile for a Medicare beneficiary in "fair" health status. Representative utilization profiles were then projected for beneficiaries in good health (lower utilization profile than for fair health status) and poor health (higher utilization profile than for fair health status). The individual utilization assumptions for these services did not change during the 1991–2001 period.

[3] Ibid.

[4] Ibid.

[5] Ibid.

Prescription Drug Assumptions (Services vary depending on health status category [G], [F], [P])	
Prescriptions[6]	> Cost-sharing is based on the applicable brand or generic copayments and the annual benefit (net of total copayments). > Ratio for brand-to-generic use is 1:1. > For 1999, brand Rx costs were based on $40 (up to 30-day supply) or $80 (90-day maintenance supply) regardless of the cost basis used by each plan (e.g., AWP, discounted cost). For 2000, brand Rx costs were based on $50 (up to 30-day supply) or $100 (90-day maintenance supply). For 2001, brand Rx costs were based on $60 (up to 30-day supply) or $120 (90-day maintenance supply) regardless of the cost basis used by each plan. > For 1999, generic Rx costs were based on $25 (up to 30-day supply) or $50 (90-day maintenance supply) regardless of the cost basis used by each plan (e.g., AWP, discounted cost). For 1999, generic Rx costs were based on $30 (up to 30-day supply) or $60 (90-day maintenance supply). For 2001, generic Rx costs were based on $36 (up to 30-day supply) or $72 (90-day maintenance supply). > [G] category includes 6 Rx total; [F] category includes 24 Rx total (average 2 Rx per month/one 90-day Rx); [P] category includes 72 Rx total (average 6 Rx per month/three 90-day Rx). > Other benefit features are not included, e.g., quarterly benefit cap, member discounts, unused annual benefit carryover.

[6] Prescription drug cost and utilization assumptions are based on the Barents Group report for the Kaiser Family Foundation, "Analysis of Benefits Offered by Medicare HMOs, 1999: Complexities and Implications" (1999). The sources for adjusting the prescription drug cost assumptions annually are information provided by selected MCOs about the average wholesale price (AWP) changes for the top brand and generic drugs covered in their Medicare+Choice formulary and publicly reported information about drug benefit cost increases incurred by MCOs for Medicare+Choice products. During the 1999–2001 period, the cost ratio assumptions for generic drugs compared with brand name drugs was 62 percent for 1999 and 60 percent for 2000–2001.

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#497 *Medicare+Choice 1999–2001: An Analysis of Managed Care Plan Withdrawals and Trends in Benefits and Premiums* (January 2002). Lori Achman and Marsha Gold, Mathematica Policy Research, Inc. The authors report that mean premium and cost-sharing levels in Medicare+Choice plans continued to increase in 2001 while coverage of prescription drugs was reduced. This trend continued despite congressional action that increased the payment rate MCOs received.

#496 *Instability and Inequity in Medicare+Choice: The Impact for Medicare Beneficiaries* (January 2002). Jennifer Stuber, Geraldine Dallek, Claire Edwards, Kathleen Maloy, and Brian Biles. This executive summary of an unpublished report—available on the Fund's website only—examines recent changes in seven Medicare+Choice markets and the effects of these changes on Medicare beneficiaries.

#495 *Physician Withdrawals: A Major Source of Instability in Medicare+Choice* (January 2002). Geraldine Dallek and Andrew Dennington, George Washington University. The authors find that provider turnover rates within Medicare+Choice plans vary dramatically from state to state. Of the 38 states with reported data for 1999, six states plus the District of Columbia had turnover rates of 20 percent or higher.

#510 *The 2002 Medicare+Choice Plan Lock-In: Should It Be Delayed?* (December 2001). Geraldine Dallek, Brian Biles, and Andrew Dennington, George Washington University. This issue brief points to large-scale health plan withdrawals and provider turnover in the Medicare+Choice market among reasons to delay or repeal the Medicare+Choice policy to lock beneficiaries into their plans for a specified period.

#491 *National and Local Factors Driving Health Plan Withdrawals from Medicare+Choice* (October 2001). Jennifer Stuber, Geraldine Dallek, and Brian Biles, George Washington University. The authors of this field report found a substantial decline in the number of Medicare+Choice plans in five of seven large markets around the country.

#490 *Restoring Choice to Medicare+Choice: The Importance of Standardizing Health Plan Benefit Packages* (October 2001). Geraldine Dallek and Claire Edwards, George Washington University. In this field report, the authors discuss the benefit packages of five Medicare+Choice plans in Cleveland, Ohio, and Tampa, Florida, and find that beneficiaries would have to spend hours calling plans, pouring over data, and making complicated calculations in order to make any kind of reasonable comparison of plans.

#474 *One-Third at Risk: The Special Circumstances of Medicare Beneficiaries with Health Problems* (September 2001). Marilyn Moon and Matthew Storeygard, The Urban Institute. In this report, the authors argue that policymakers contemplating changes to the entitlement program for the

elderly and disabled must take steps to protect the most vulnerable beneficiaries—those with chronic or acute physical or cognitive ailments—from incurring out-of-pocket expenses that are even higher than what they currently bear.

#470 *Medicare+Choice: An Interim Report Card* (July/August 2001). Marsha Gold, Mathematica Policy Research, Inc. *Health Affairs,* vol. 20, no. 4. The author gives Medicare+Choice (M+C) a "barely passing grade," noting disparities between what Congress intended under M+C and what was achieved. The author suggests that while operational constraints help explain experience to date, fundamental disagreements in Congress over Medicare's future mean that dramatic growth in M+C was then, and remains now, highly unlikely.

#467 *Raising Payment Rates: Initial Effects of BIPA 2000* (June 2001). Marsha Gold and Lori Achman, Mathematica Policy Research, Inc. This "Fast Facts" brief, published by Mathematica, examines how the Benefits Improvement and Protection Act (BIPA) changed payment rates to Medicare+Choice plans in counties with a metropolitan area of 250,000 people or more. Available online at www.mathematica-mpr.com/PDFs/fastfacts6.pdf *or* www.cmwf.org/programs/medfutur/gold_bipa_467.pdf.

#463 *Strengthening Medicare: Modernizing Beneficiary Cost-Sharing* (May 2001). Karen Davis. In invited testimony before a House Ways and Means Health Subcommittee hearing , the Fund's president cautioned that any effort to reform Medicare's benefit package must take into account the circumstances of all beneficiaries, including those who are older, low-income, and chronically ill.

#461 *Reforming Medicare's Benefit Package: Impact on Beneficiary Expenditures* (May 2001). Stephanie Maxwell, Marilyn Moon, and Matthew Storeygard, The Urban Institute. This report presents four possible options for modernizing Medicare that would reverse spiraling costs for beneficiaries and reduce or eliminate the need for private supplemental insurance.

Medicare Works (Spring 2001). Bruce Vladeck. *Harvard Health Policy Review,* vol. 2, no. 1. Reprinted from *New Jersey Medicine,* March 2000. Available online at http://hcs.harvard.edu/~epihc/currentissue/spring2001/vladeck.html.

#460 *Trends in Premiums, Cost-Sharing, and Benefits in Medicare+Choice Health Plans, 1999–2001* (April 2001). Marsha Gold and Lori Achman, Mathematica Policy Research, Inc. This issue brief provides an early look at trends in Medicare+Choice plans from 1999 to 2001, revealing continued growth in premiums and a simultaneous continued decline in benefit comprehensiveness.

#498 *Dynamics in Drug Coverage of Medicare Beneficiaries: Finders, Losers, Switchers* (March/April 2001). Bruce Stuart, Dennis Shea, and Becky Briesacher. *Health Affairs,* vol. 20, no. 2. The authors analyze the sources and stability of prescription coverage maintained by Medicare beneficiaries in 1995 and 1996. The results show that fewer than half of all beneficiaries had continuous drug coverage over this period, while nearly a third gained, lost, or had spells without coverage.

Health Policy 2001: Medicare (March 22, 2001). Marilyn Moon. *New England Journal of Medicine,* vol. 344, no. 12. Copies are available from Customer Service, New England Journal of Medicine, P.O. Box 549140, Waltham, MA 02454-9140, Fax: 800-THE-NEJM, (800-843-6356), www.nejm.org.

#430 *Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries* (January 2001). Stephanie Maxwell, Marilyn Moon, and Misha Segal, The Urban Institute. Medicare beneficiaries will have to pay substantially more out of their own pockets for health care in the future, according to this new report. The authors find that those with low incomes and health problems will be at even greater risk than average beneficiaries for costs such as Medicare premiums, medical services, and prescription drugs.

A Moving Target: Financing Medicare for the Future (Winter 2000/2001). Marilyn Moon, Misha Segal, and Randall Weiss, The Urban Institute. *Inquiry,* vol. 37, no. 4. Copies are available from *Inquiry,* P.O. Box 527, Glenview, IL 60025, Tel: 847-724-9280.

#436 *Designing a Medicare Drug Benefit: Whose Needs Will Be Met?* (December 2000). Bruce Stuart, Becky Briesacher, and Dennis Shea. Many current proposals for providing a prescription drug benefit under Medicare would cover only beneficiaries with incomes at the federal poverty level or slightly above. In this issue brief, the authors propose a broader definition of need that includes beneficiaries without continuous and stable coverage, those with high expenditures, and those with multiple chronic conditions. Under this expanded definition, nearly 90 percent of beneficiaries would be eligible for coverage.

Socioeconomic Differences in Medicare Supplemental Coverage (September/October 2000). Nadereh Pourat, Thomas Rice, Gerald Kominski, and Rani E. Snyder. *Health Affairs,* vol. 19, no. 5. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#395 *Early Implementation of Medicare+Choice in Four Sites: Cleveland, Los Angeles, New York, and Tampa–St. Petersburg* (August 2000). Geraldine Dallek and Donald Jones, Institute for Health Care Research and Policy, Georgetown University. This field report, based on research cofunded by The Commonwealth Fund and the California Wellness Foundation, examines the effects of Medicare+Choice—created by the Balanced Budget Act of 1997—on Medicare beneficiaries in four managed care markets.

#394 *Medicare+Choice in 2000: Will Enrollees Spend More and Receive Less?* (August 2000). Amanda Cassidy and Marsha Gold, Mathematica Policy Research, Inc. Using information from HCFA's Medicare Compare consumer-oriented database of Medicare+Choice plans, this report provides a detailed look at changes in benefits offered under Medicare+Choice in 1999–2000, focusing on benefit reductions and small capitation rate increases that are shifting costs to beneficiaries.

#393 *What Do Medicare HMO Enrollees Spend Out-of-Pocket?* (August 2000). Jessica Kasten, Marilyn Moon, and Misha Segal, The Urban Institute. Medicare+Choice plans are scaling back benefits and shifting costs to enrollees through increases in service copayments and decreases in the value of prescription drug benefits. This report examines the financial effects of these actions on Medicare managed care enrollees.

#405 *Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70* (July 2000). Cathy Schoen, Elisabeth Simantov, Lisa Duchon, and Karen Davis. This summary report, based on *The Commonwealth Fund 1999 Health Care Survey of Adults Ages 50 to 70,* reveals that those nearing the age of Medicare eligibility and those who recently enrolled in the program place high value on Medicare. At the same time, many people in this age group are struggling to pay for prescription drugs, which Medicare doesn't cover.

#406 *Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70* (July 2000). Cathy Schoen, Elisabeth Simantov, Lisa Duchon, and Karen Davis. This full report of findings from *The Commonwealth Fund 1999 Health Care Survey of Adults Ages 50 to 70* reveals that those nearing the age of Medicare eligibility and those who recently enrolled in the program place high value on Medicare. At the same time, many people in this age group are struggling to pay for prescription drugs, which Medicare doesn't cover.

#371 *An Assessment of the President's Proposal to Modernize and Strengthen Medicare* (June 2000). Marilyn Moon, The Urban Institute. This paper discusses four elements of the President's proposal for Medicare reforms: improving the benefit package, enhancing the management tools available

for the traditional Medicare program, redirecting competition in the private plan options, and adding further resources to ensure the program's security in the coming years.

#382 *Drug Coverage and Drug Purchases by Medicare Beneficiaries with Hypertension* (March/April 2000). Jan Blustein. *Health Affairs,* vol. 19, no 2. This article shows that Medicare beneficiaries age 65 and older with high blood pressure are less likely to purchase hypertension medication if they are without drug coverage.

Who Is Enrolled in For-Profit vs. Nonprofit Medicare HMOs? (January/February 2000). Jan Blustein and Emma C. Hoy. *Health Affairs,* vol. 19, no. 1. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#365 *Prescription Drug Costs for Medicare Beneficiaries: Coverage and Health Status Matter* (January 2000). Bruce Stuart, Dennis Shea, and Becky Briesacher. This issue brief reports that prescription drug coverage of Medicare beneficiaries is more fragile than previously reported, that continuity of this coverage makes a significant difference in beneficiaries' use of prescription medicine, and that health status affects drug coverage for beneficiaries primarily through their burden of chronic illness.

#360 *Understanding the Diverse Needs of the Medicare Population: Implications for Medicare Reform* (November 1999). Tricia Neuman, Cathy Schoen, Diane Rowland, Karen Davis, Elaine Puleo, and Michelle Kitchman. *Journal of Aging and Social Policy,* vol. 10, no. 4. This profile of Medicare beneficiaries, based on an analysis of the *Kaiser/Commonwealth 1997 Survey of Medicare Beneficiaries,* reveals that a relatively large share of the Medicare population has serious health problems and low incomes.

#353 *After the Bipartisan Commission: What Next for Medicare?* (October 1999). Stuart H. Altman, Karen Davis, Charles N. Kahn III, Jan Blustein, Jo Ivey Boufford, and Katherine E. Garrett. This summary of a panel discussion held at New York University's Robert F. Wagner Graduate School of Public Service considers what may happen now that the National Bipartisan Commission on the Future of Medicare has finished its work without issuing recommendations to the President. It also examines possible reform opportunities following the November 2000 elections.

#346 *Should Medicare HMO Benefits Be Standardized?* (July/August 1999). Peter D. Fox, Rani Snyder, Geraldine Dallek, and Thomas Rice. *Health Affairs,* vol. 18, no. 4. The only Medicare supplement (Medigap) policies that can be sold are those that conform to the 10 standardized packages outlined in federal legislation enacted in 1990. In this article the authors address whether Medicare HMO benefits should also be standardized for the roughly 6 million Medicare beneficiaries now enrolled in HMOs.

#232 *Risk Adjustment and Medicare* (June 1999). Joseph P. Newhouse, Melinda Beeuwkes Buntin, and John D. Chapman, Harvard University. Medicare's payments to managed care plans bear little relationship to the cost of providing needed care to beneficiaries with different health conditions. In this revised paper, the authors suggest using two alternative health risk adjusters that would contribute to more cost-effective care and reduce favorable risk selection and the incentive to stint on care.

#318 *Growth in Medicare Spending: What Will Beneficiaries Pay?* (May 1999). Marilyn Moon, The Urban Institute. Using projections from the 1998 Medicare and Social Security Trustees' reports to examine how growth in health care spending will affect beneficiaries and taxpayers, the author explains that no easy choices exist that would both limit costs to taxpayers while protecting Medicare beneficiaries from the burdens of health care costs.

#317 *Restructuring Medicare: Impacts on Beneficiaries* (May 1999). Marilyn Moon, The Urban Institute. The author analyzes premium support and defined contribution—two of the more

prominent approaches proposed to help Medicare cope with the health care needs of the soon-to-retire baby boomers—and projects these approaches' impacts on future beneficiaries.

#310 *Should Medicare HMO Benefits Be Standardized?* (February 1999). Peter D. Fox, Rani Snyder, Geraldine Dallek, and Thomas Rice. The only Medicare supplement (Medigap) policies that can be sold are those that conform to the 10 standardized packages outlined in federal legislation enacted in 1990. In this paper the authors address whether Medicare HMO benefits should also be standardized for the roughly 6 million Medicare beneficiaries now enrolled in HMOs.

Budget Bills and Medicare Policy: The Politics of the BBA (January/February 1999). Charles N. Kahn III and Hanns Kuttner. *Health Affairs,* vol. 18, no. 1. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

Will the Care Be There? Vulnerable Beneficiaries and Medicare Reform (January/February 1999). Marilyn Moon. *Health Affairs,* vol. 18, no. 1. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

The Political Economy of Medicare (January/February 1999). Bruce C. Vladeck. *Health Affairs,* vol. 18, no. 1. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#308 *Medicare Beneficiaries: A Population at Risk—Findings from the* Kaiser/Commonwealth 1997 Survey of Medicare Beneficiaries (December 1998). Cathy Schoen, Patricia Neuman, Michelle Kitchman, Karen Davis, and Diane Rowland. This survey report, based on beneficiaries' own accounts of their incomes and health status, points to serious challenges in insuring an aging, vulnerable population.

#294 *Improving Coverage for Low-Income Medicare Beneficiaries* (December 1998). Marilyn Moon, Niall Brennan, and Misha Segal, The Urban Institute. The authors examine ways in which the Qualified Medicare Beneficiary and related programs could be modified to increase participation and protect more sick and low-income Medicare beneficiaries.

#302 *The Future of Medicare* (November 1998). Brian Biles, Susan Raetzman, Susan Joseph, and Karen Davis. This issue brief discusses the two ways in which the National Bipartisan Commission on the Future of Medicare is examining the Medicare program and making recommendations to keep it fiscally healthy into the twenty-first century: through the development of incremental reforms and the analysis of major restructuring. The authors also discuss projections of the future costs of care and sources of revenues to finance care for the elderly and disabled.

#272 *Shaping the Future of Medicare* (April 1998). Karen Davis. Presented as invited testimony before the National Bipartisan Commission on the Future of Medicare's hearing on "Medicare and the Baby Boomers" on April 21, 1998, this report suggests ways to prepare the Medicare program for the challenge of coping with unprecedented numbers of elderly and disabled Americans. The author identifies several principles to guide the debate.